United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 09-1128**
	)	**Issued: December 7, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Fayetteville, NC, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 24, 2009 appellant filed a timely appeal from a March 12, 2009 decision of the Office of Workers' Compensation Programs regarding his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than five percent permanent impairment of the left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On February 15, 2007 appellant, then a 59-year-old letter carrier, injured his left shoulder when he was involved in a motor vehicle accident while delivering mail. The Office accepted his claim for sprain of the left shoulder/upper arm and other specified sites and authorized arthroscopic surgery which was performed on May 14 and September 24, 2007. Appellant did not stop work.

Appellant was treated at an urgent care center on February 15 and March 5, 2007 and was diagnosed with myalgia. A magnetic resonance imaging (MRI) scan of the left shoulder dated

April 3, 2007 revealed supraspinatus calcific tendinosis, as well as a focal full thickness tendon tear, subcoracoid bursa effusion and mild supraspinatus outlet narrowing due to acromioclavicular joint osteoarthritis. Dr. Douglas McFarlane, a Board-certified orthopedic surgeon, performed surgery on May 14, 2007 for an open acromioplasty and repair of the rotator cuff of the left shoulder and diagnosed impingement syndrome with torn left rotator cuff. On September 24, 2007 he performed manipulation of the left shoulder under anesthesia. On March 11, 2008 Dr. McFarlane advised that appellant reached maximum medical improvement. He noted findings upon examination of full range of motion for both shoulders and full strength in the left arm and opined that appellant had 10 percent permanent impairment of the left shoulder. Dr. McFarlane released appellant from his care with no work restrictions.

On May 7, 2008 appellant filed a claim for a schedule award.

On May 13, 2008 an Office medical adviser found that appellant had no impairment of the left arm. The medical adviser noted that Dr. McFarlane performed an open acromioplasty on May 14, 2007 and that appellant reached maximum medical improvement with normal range of motion and full strength. The medical adviser also noted that Dr. McFarlane found 10 percent impairment of the left arm but failed to explain how he arrived at this rating.

On May 16, 2008 the Office requested that Dr. McFarlane address the extent of permanent partial impairment to appellant's the left shoulder pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment.* In an August 29, 2008 report, Dr. McFarlane explained his impairment rating, noting that appellant underwent an open acromioplasty and repair of the rotator cuff of the left shoulder on May 14, 2007 and subsequently had stiffness due to adhesive capsulitis. Dr. McFarlane noted findings upon examination revealed full range of motion of the left shoulder and full strength. He opined that appellant would have to exercise caution to avoid tearing the rotator cuff and, for this reason, he found 10 percent impairment in accordance with the A.M.A., *Guides*.

In a September 11, 2008 report, an Office medical adviser reiterated that appellant had zero percent impairment of the left arm. He noted that appellant reached maximum medical improvement with normal range of motion and full strength. The medical adviser noted that Dr. McFarlane did not explain his calculation of 10 percent impairment.

On October 15, 2008 the Office again requested that Dr. McFarlane review the medical adviser's impairment rating. On October 27, 2008 Dr. McFarlane opined that appellant had a 10 percent impairment rating of the left shoulder as previously determined. He concurred that appellant had regained full range of motion and strength in his left arm; however, he noted that appellant did not have a normal shoulder due to the extensive tear of the rotator cuff. Dr. McFarlane recommended restrictions for appellant to avoid future injury to the shoulder.

On February 5, 2009 the Office referred appellant for a second opinion to Dr. William Somers, a Board-certified orthopedic surgeon, for determination of permanent impairment in accordance with the A.M.A., *Guides.* In a February 18, 2009 report, Dr. Somers reviewed the history of injury and medical treatment. He noted the history of appellant's shoulder conditions and diagnosed complex and significant left rotator cuff tear, status post repair of the left rotator cuff tear and status post closed manipulation secondary to arthrofibrosis. Dr. Somers advised that appellant underwent acromioplasty and repair of the complex rotator cuff tear. He found that left shoulder abduction was 90 degrees, adduction was 30 degrees, internal rotation was 50

degrees, external rotation was 45 degrees, flexion was 180 degrees and extension was 40 degrees, for a total 5 percent impairment of the left arm for loss of range of motion. Dr. Somers noted additional impairment for motor weakness of the left arm due to weakness around the scapular nerve for a two percent impairment[1] and three percent impairment for the risk of retear of the repair and future rotator cuff arthroplasty associated with the injury pursuant to "section 1.7" of the A.M.A., *Guides*. He recommended 10 percent impairment of the left upper extremity under the A.M.A., *Guides*. Dr. Somers noted that appellant reached maximum medical improvement.

On March 2, 2009 the Office medical adviser found that appellant had five percent impairment of the left upper extremity due to loss of range of motion. The medical adviser noted that Dr. Somers allowed five percent impairment due to weakness and the possibility of future rotator cuff arthropathy. However, the medical adviser noted that page 508 of the A.M.A., *Guides*, does not allow the use of weakness in the presence of motion, pain, deformity in calculating impairment.

By decision dated March 12, 2009, the Office granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The period of the award was from March 11 to June 28, 2008.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.

ANALYSIS

The Office accepted appellant's claim for sprain of the left shoulder/upper arm and other specified sites. It authorized arthroscopic surgery which was performed on May 14 and September 24, 2007. On appeal, appellant contends that he has 10 percent impairment consistent with the reports of Drs. McFarlane and Somers. However, the Board finds that appellant has no more than nine percent permanent impairment of the left arm.

In reports dated March 11 to October 27, 2008, Dr. McFarlane advised that appellant had reached maximum medical improvement and had 10 percent permanent impairment due to his

[1] *Id.* at 492, Figure 16-15.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

left shoulder injury. However, he did not explain how he made this rating pursuant to the A.M.A., *Guides*.[4] Therefore, Dr. McFarlane's rating is of diminished probative value.

The Office referred appellant to Dr. Somers for a second opinion evaluation. In his report dated February 18, 2009, Dr. Somers noted left shoulder abduction was 90 degrees, adduction was 30 degrees, internal rotation was 50 degrees, external rotation was 45 degrees, flexion was 180 degrees and extension was 40 degrees, for a total of 5 percent impairment for loss of range of motion. The Office medical adviser concurred in this determination. However, Dr. Somers and the Office medical adviser incorrectly noted that loss of range of motion for the shoulder totaled five percent impairment. The Board notes that the A.M.A., *Guides* provide that abduction of 90 degrees is four percent impairment,[5] adduction of 30 degrees is one percent impairment,[6] internal rotation of 50 degrees is two percent impairment,[7] external rotation of 45 degrees is one percent impairment,[8] flexion of 180 degrees is zero percent impairment,[9] and extension of 40 degrees is one percent impairment.[10] This totals nine percent impairment for loss of shoulder motion to the left upper extremity.

With regard to impairment for strength deficit, Dr. Somers noted impairment of the left upper extremity due to motor weakness around the scapular nerves pursuant to Table 16-15 of the A.M.A., *Guides* for two percent impairment. However, the A.M.A., *Guides*, provide under section 16.8, that decreased strength cannot be rated in the presence of decreased motion.[11] Consequently, impairment attributable for decreased strength under section 16.8 cannot be combined with impairment for decreased motion. The A.M.A., *Guides* provide that only in rare cases, if the examiner believed the individual's loss of strength represents an impairment factor that has not been considered adequately by other methods in the A.M.A., *Guides*, then the loss of strength can be rated separately.[12] In this instance, Dr. Somers did not explain why strength impairment should be rated separately from the range of motion impairment. Dr. Somers also found three percent impairment for the risk of retear of the repair and future rotator cuff arthroplasty associated with the injury pursuant to "section 1.7" of the A.M.A., *Guides*. However, this finding is not in conformance with measurements on which ratings are based in the A.M.A., *Guides.* Chapter 1.7 of the A.M.A., *Guides* contains no specific provision for

[4] *Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

[5] A.M.A., *Guides*, 477, Figure 16-43.

[6] *Id.*

[7] *Id.* at 479, Figure 16-46.

[8] *Id.*

[9] *Id.* at 476, Figure 16-40.

[10] *Id.*

[11] *See id.* at 508, section 16.8a.

[12] *Id.*

apportioning particular degrees of impairment due to the risk of reinjury.[13] Additionally, fear of future injury is not compensable under the Act.[14]

The loss of range of motion to appellant's shoulder totals nine percent impairment of the left upper extremity. The Board will modify the Office's impairment rating to reflect this degree of permanent impairment.

CONCLUSION

The Board finds that appellant has no more than nine percent permanent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the March 12, 2009 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: December 7, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[13] *See id.* at 12.

[14] *See Mary Geary,* 43 ECAB 300, 309 (1991); *Pat Lazzara,* 31 ECAB 1169, 1174 (1980) (finding that appellant's fear of a recurrence of disability upon return to work is not a basis for compensation).